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NYSBA

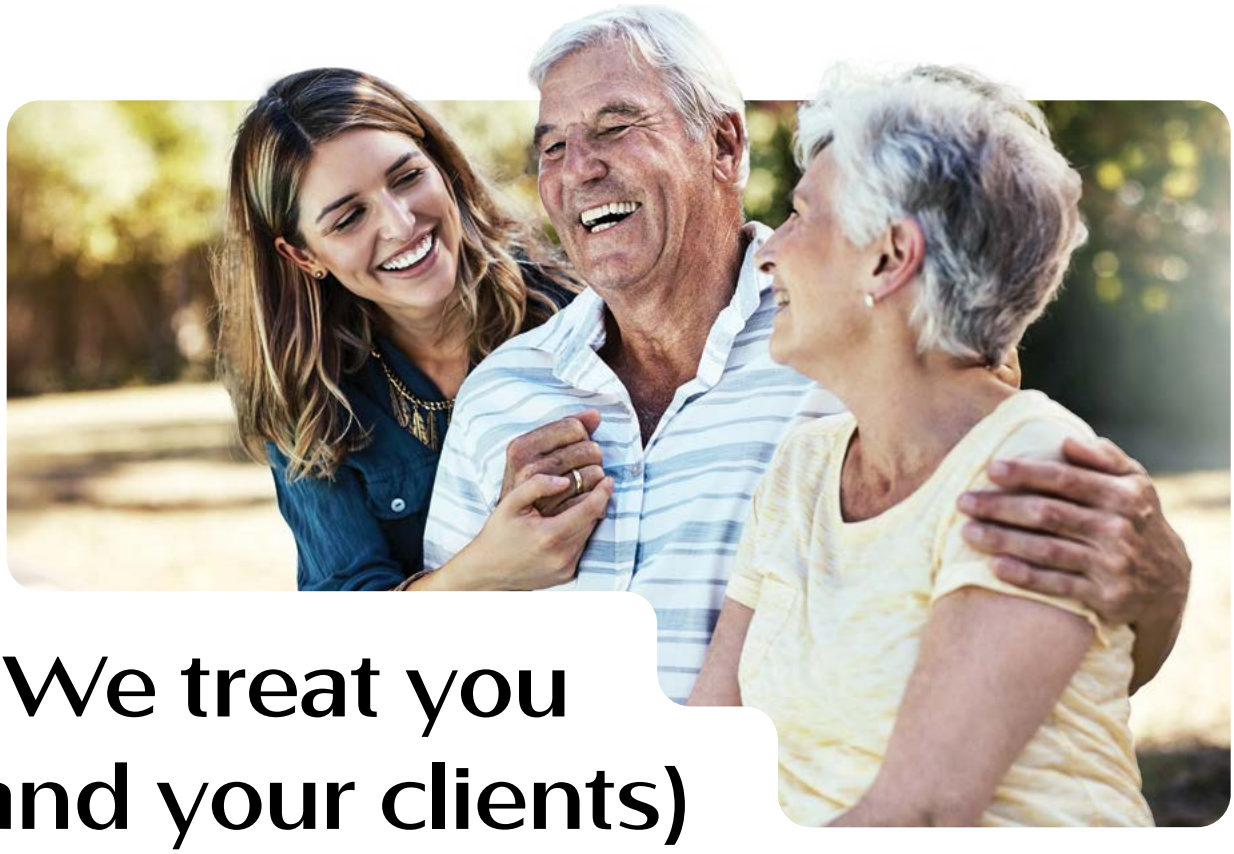
Elder and Special Needs Law Journal

A publication of the Elder Law and Special Needs Section of the New York State Bar Association

Why New York Is One of the Best States for Medicare Beneficiaries

The History of the United States Department of Education Explained

Interim – State of Estates



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This publication is a benefit of membership of the Elder Law and Special Needs Section of the New York State Bar Association. Persons interested in writing for this newsletter are welcomed and encouraged to submit their articles for consideration to Katherine Carpenter (kcarpenter@wplawny.com) and Lauren Enea (l.enea@esslawfirm.com).

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Message From the Section Chair

By Britt Burner

Dear Section Members:

At the time of this writing, spring is upon us! For many, this may draw up visuals of flowers and chirping birds; for some of us it brings thoughts of budget season, Albany, and legislative advocacy. While members of the Executive Committee are hard at work on legislative issues year-round, the intensity heightens in February, March, and April.

Governor Hochul's 2025-2026 proposed New York State budget bill was relatively quiet on the Medicaid front, but the Section has decided to continue pushing for the repeal of two specific provisions left over from the NYS 2020-2021 Budget: 1) repeal of the 30-month look-back for Community Medicaid applications, and 2) repeal of the ADL requirement for personal care services, Consumer Directed Personal Assistance Program, and inclusion in Managed Long Term Care. Beyond the Medicaid provisions, the Section is continuing to take our long-held position supporting language enforcing a transaction hold in circumstances of potential exploitation of elderly or vulnerable persons. This is not the first year that a similar initiative made its way into the proposed budget and we are hopeful that this important legislation can find its way into New York law. The three position memos of the Section are included in this issue of this journal.

After our initial positions were put forth, the one-house bills came out. This is where the Assembly and Senate put forth their own proposed budgets, which starts negotiations between the three arms of government, Assembly, Senate, Executive. A special Executive Committee meeting of the Section was held on March 19 to discuss and take a position on two additional issues. The first was a Senate proposal to raise the resource allowance for Medicaid eligibility to $300,000. After a debate of the pros and cons, the Executive Committee voted to support this language. The Executive Committee also voted to support a Senate proposal that would serve to reject a pro-

continued on page 4

posal from the governor to cap enrollment in the Nursing Home Transition and Diversion waiver program.

Before we made it to spring, we were all able to gather at the Hilton Midtown for the NYSBA Annual Meeting. In the business portion of the meeting, section positions, awards and scholarships were presented by Fern Finkel, chair of the Nomination Committee and immediate past chair of the Section. Sara Meyers, Ira Salzman and Sheila Shea were named as Section members-at-large. For the positions of district delegates, Tommaso Marasco was named for the First District, William Pfeiffer for the Third, Kathleen T. Hoppin for the Seventh, and Lisa R. Valente for the Tenth. The 2025-2026 slate of officers will be:

- Richard Marchese as section chair;
- Tammy R. Lawlor as chair-elect;
- Lindsay Heckler as vice-chair;
- David Kronenberg as secretary;
- Deborah Ball as treasurer.

In addition, the Nominating Committee awarded two scholarships. The first is given in memory of the Honorable Joel K. Asarch, a former Nassau County Supreme Court justice who presided over guardianship matters, ruling with compassion and bringing dignity to the cases before him. The 2025 recipient of the Hon. Joel K. Asarch Elder Law and Special Needs Section Scholarship was **Callie Costanza**, a second-year student at Hofstra University School of Law. The second scholarship is in memory of David Stapleton, our beloved former Section chair (and self-proclaimed "antique chair") from Auburn, N.Y., who passed away in 2020. The 2025 recipient of the T. David Stapleton Memorial Scholarship was **Madison Marshall**, a second-year student at Albany Law School

The nominating committee also acknowledged those who have furthered the goals of the Section. This year, the committee saw fit to give four awards, the Judiciary Award, Advocate for the Elderly, Friend of the Section, and Lifetime Achievement.

The Judiciary Award was presented to the **Honorable Bernice D. Siegal**, in recognition of her commitment to the elderly or disabled. Judge Siegal is a justice of the New York State Supreme Court, Queens County, in the Guardianship Part She exemplifies civic involvement, dedicating herself to the good of the public, in particular those who cannot advocate for themselves: our elderly and those with special needs. She is kind, devoted, and a fierce member of the judiciary.

Paul Fellin was this year's recipient of the Advocate for the Elderly Award. Paul was successful in a Fair Hearing overturning a Medicaid denial based on the issue of trust assets being available to the grantor based upon a trust power to "improve" property. He advocated successfully to explain why the power to improve property held in his client's Medicaid Asset Protection Trust should not result in the trust assets being considered "available" to the grantor. Way to go, Paul!

The Friend of the Section Award is for an attorney who went above and beyond their role and duties to advocate for the needs of the clients we represent. This year we are happy to honor **Sheila Shea**. Sheila Shea retired at the end of 2024 after serving for 17 years as the director of the Third Judicial Department of the Mental Hygiene Legal Service, where she provided legal services to individuals with mental health and developmental disabilities.

Last, but certainly not least, is the Lifetime Achievement Award, given in recognition of a career of dedicated service to the Elder Law and Special Needs Section in furtherance of the rights of the elderly and disabled. We were thrilled to present this to **Robert Abrams**. Bob was a co-founder of our Section. During his tenure, he created Health care Decision Making Day and participated in creating a structure and strategy to meet with legislators in New York and Washington, D.C. Thank you, Bob!

Congratulations To All and Thank You To The Nominating Committee!

With the business of the Section out of the way, we were able to get on with a fabulous lineup of CLEs with topics including a local and national elder law update, Medical Aid in Dying, understanding investment vehicles and how to plan with them for you and your client, and Medicaid and estate planning circumstances that can lead to litigation. Thank you to Matthew Nolfo and Donna Stefans for putting this informative program together and thank you to our presenters.

As always, we had a great turnout of sponsors attending the meeting. Sponsors not only generously give to our Section but they also provide wonderful services that run parallel to many of our practices and can greatly assist our clients.

Join Us For One Of Our Upcoming Meetings

- **2025 Summer Meeting** – July 17-19, 2025, at the Sheraton Inner Harbor Hotel, Baltimore, MD.
- **2025 Fall Meeting** – October 23-24, 2025 – at High Peaks Resort, Lake Placid, NY.

Do not forget that anyone can be involved in committee meetings and advocacy. If you are interested in staying informed on a certain subject, joining the committee is an easy way to get notification of the meeting dates and times. We would love to have you!

If you want to see your name in print… submit an article for an upcoming issue of the Elder and Special Needs Law Journal! the next deadline for submission is July 10, 2025 to Lauren C. Enea at L.Enea@esslawfirm.com.

Be well,
Britt

Message from the Co-Editors

Lauren C. Enea

Katherine Carpenter

This message from the Co-Editors is a bittersweet one! After a number of years as Co-Editor, Katherine (Katy) Carpenter, will be stepping down to pursue other roles in our Section. We are sad to see Katy go, but are incredibly grateful for her contributions to the Journal and our section! Thank you, Katy!

This issue showcases three articles along with five Lobbying Memos for your perusal. Please be sure to review the Lobbying Memos, which outline the Section's position as to a number of important issues.

First we hear from our friend, and frequent contributor Paul S. Forster with an Interim State of Estates. This State of Estates focuses on compensation of a Guardian ad Litem (GAL). The GAL position is one that many of us have held from time to time and this is a must read for anyone who acts as a GAL.

The next article is the second Education Law Column from Adrienne Arkontaky and Irina Roller. With much change in the federal government and new administration, Adrienne and Irina bring us back to basics with a history lesson on the United States Department of Education- a hot topic in politics currently!

Our third article is from our section chair Britt Burner and Brian Krantz, a Medicare Advisor, who provide us with an excellent primer on Medicare benefits. As Elder Law attorneys we are frequently asked to advise clients not only as to their Medicaid benefits but Medicare benefits as well.

Lastly, please be sure to review our Member Spotlight of Robert Arbuco, Esq., and our always witty Comic Strip by Antony Eminowicz!

Our next journal will; be released in the Fall of 2026 and content is due to our committee by July 10, 2025. Please send all submissions to Lauren C. Enea at L.Enea@esslawfirm.com.

Thank You and Happy Reading!
Lauren & Katy

Interim – State of Estates

By Paul S. Forster

Our latest installment concerns an implicit aspect of the compensation of those who serve as guardian *ad litem,* which might serve as a trap for the unwary.

In a probate proceeding the court appointed a guardian *ad litem* (GAL) to protect the interests of a distributee whose whereabouts were unknown. The GAL filed a six-page report recommending that decedent's will be admitted to probate. The GAL also filed an affirmation of services rendered and hourly breakdown, which stated he and members of his staff devoted over 17 hours to services as GAL and requested to be paid $7,615.50 in legal fees plus $15.20 in reimbursement for postage.

The nominated executor, who was the petitioner in the probate proceeding, filed an affirmation objecting to the GAL's legal fees. The petitioner argued that the GAL was inexperienced and billed for many hours that did not reflect the actual time required to complete the task. He noted that much of his communications with the GAL's office were with two of GAL's associates. Petitioner complained that it took over seven months for the GAL to submit his report, that the invoices charged over four hours for a one-hour conference, that there was a time entry for a meeting with him that never occurred, and that the GAL's office had failed to respond to petitioner's communications while the file remained largely dormant for five months.

The GAL filed an affirmation in response to the objection to his fees in which he stated that one of his associates had handled the primary bulk of the work before her departure, and that the other associate reviewed the file and ascertained details from notes in continuing to work on the case. The GAL stated, "I fully understand that the internal happenings at our firm do not justify additional expense to Decedent's Estate and merely attempt to give context to the legal work that was done in this matter." He also contended that the case was no routine matter.

HOLDING: The court ruled that it would only award compensation for substantive legal services rendered by the GAL personally.

The Court opined that the determination of reasonable compensation to be awarded to a GAL is within the sound discretion of the Court, and that the burden with respect to establishing the reasonable value of legal services performed rested on the attorney performing those services.

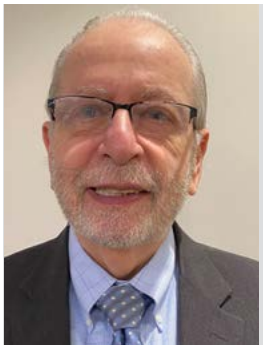
The Court added that the appointment of a GAL is personal and, as such, the GAL should assume all responsibility for the matter and is expected to perform all of the substantive legal services on the case. The Court held that that duty cannot be delegated to someone else. The Court acknowledged that compensation might be allowed for a portion of work by the associates of a GAL, when the records showed that their work was supervised by the GAL.

The Court reiterated the well-known factors in determining reasonable compensation for legal services rendered by the GAL, the time spent, the complexity of the questions involved, the nature of the services provided, the amount of litigation required, the amounts involved, the benefit resulting from the performance of such services, the lawyer's experience and reputation, and the customary fee charged by the Bar for similar services.

The Court noted that the GAL reported that he and members of his staff spent over 17 hours working on the appointment, including writing his six-page report, with rates ranging from $280 to $600 per hour, but that the hourly breakdown submitted did not state which attorney performed which time entry and no affirmations by GAL's associates were submitted.

The Court found that there was no question that the GAL's associates performed the bulk of the work in the assignment.

Consequently, the Court held that since it had appointed the GAL personally to protect his ward's interests, not his associates, and in any event the associates were not eligible to serve as guardians *ad litem* in New York County, the Court only would award compensation for substantive legal services rendered by the GAL, personally. *Matter of Wolf*, N.Y.L.J. 7/26/24, p.17, c.1 (Surr. Ct., New York Co., Surr. Gingold).



Paul S. Forster is a sole practitioner in Tuckahoe, New York. He is co-chair of the Trusts and Estates Law Section's Estate and Trusts Administration Committee.

The History of the United States Department of Education Explained

By Adrienne Arkontaky and Irina Roller

With a new Secretary of Education and a new administration determined to cut federal spending, we are faced with the prospect of drastically reducing (or abolishing) the U.S. Department of Education's (DOE) role in today's education system.

The message from the Trump administration is to return the oversight of education to the states and make major changes to the two major funding streams the Department oversees including the Individuals with Disabilities in Education Act (IDEA) and ending Title I of the Elementary and Secondary Education Act for schools. With the prospect of a closure looming, it is important that special needs planners, special education attorneys and advocates understand how the Department works and the impact of the proposed changes.

President Jimmy Carter created the federal Department of Education in 1979 under Public Law 96-88. President Carter's vision was to provide a department to ensure equal access to all regardless of race, creed, color, national origin, or sex. Prior to that time, most policies and enforcement of the existing education laws on the federal level were handled by the U.S. Department of Health and Human Services. President Carter's goal was to support education of students from poor communities through the enactment of Title I. Ten years later Congress enacted the Education for All Handicapped Children Act, which eventually became the Individuals with Disabilities in Education Act (IDEA). The intent was to provide equal access to education regardless of economic status. With the enactment of these pieces of legislation, in 1979, the U.S. Department of Education was born.

However, many individuals do not understand what the Department does, the actual authority and oversight it provides, or the amount of funding it provides to the states, which is less than 10% of the spending on education and other programs. In addition, many of the decisions regarding education are left primarily to the states to determine.

The federal Department of Education, a cabinet level executive branch agency, oversees education policy and administers a budget of nearly $268 billion (spent in 2024) for programs from pre-kindergarten through post-secondary education. It provides grants through Title I and the IDEA provides funding to the states that help local school districts provide necessary supports for students with special education needs. In addition, the federal Department of Education provides oversight of funding and regulations during emergencies, such as the COVID pandemic. It is important to

remember that while the federal government provides some funding, the states also are responsible for providing financial supports for education.

There are many offices that are part of the federal Department of Education including the Office of Elementary and Secondary Education, the Office of English Language Acquisition, the Office of Special Education and Rehabilitation Services, the Institute of Education Sciences, the Office for Civil Rights and the Office of Career, Technical and Adult Education.

There are other departments that administer programs including the Department of Health and Human Services and the Department of Agriculture that underwrites the school lunch program.

The Department of Education has been tasked with research including how to improve academic performance of students in our schools. Other initiatives include increasing access to education to students from underserved and low-income communities. It is also important to note that the federal Department of Education oversees student loan programs and provides funding such as Pell grants.

Probably one of the most important roles of the Department is to oversee compliance with many of the civil rights laws. The Office of Civil Rights (OCR) handles civil rights complaints including investigation, resolution and compliance issues. The Department has been tasked with ensuring civil rights laws, including Title IX and violations of the IDEA, are addressed. Violations of these and other statutes may result in a loss of funding.

The Department is headed by a Secretary of Education nominated by the President and confirmed by the Senate. Linda McMahon was confirmed by the Senate and is the current Secretary of Education.

The debate regarding the value of the federal Department of Education is not new. With each administration, the Department's role and the desire to improve outcomes for students have been an important campaign issue. Each administration has its own vision for the provision of education and how to best serve students including those with disabilities. While total elimination of the Department remains unlikely, as it would take an act of Congress, there have been proposals over the years to shift the oversight and funding to other departments, raising the issue of whether students will be better served in this manner.

If this happens, there is an argument that the states, including local education agencies, may not see a difference.

On the other hand, if there is a change in the education laws or funding streams, of course, the impact could be far more sweeping.

For special needs planners, we believe that one point to consider is whether there needs to be more consideration for how to provide long-term care if changes to the funding streams do occur.

For special education attorneys, we need to consider zealously advocating for the rights of students with disabilities on a state level to ensure they continue to receive access to supports mandated under the law.

As potential changes unfold, it is crucial for attorneys and advocates to work across party lines to ensure that education remains a bipartisan priority.

The purpose of this column is to provide the reader with a basic understanding of the agency and not to provide an opinion on the impact of change. We hope this column provides a starting point for creative planning and conversation.

Adrienne Arkontaky is the founder/owner of the Arkontaky Law Group. Her practice focuses on special education advocacy/litigation/special needs planning/trust administration/guardianships, and Office of Persons with Disabilities applications and appeals.

Irina Roller is the founder/owner of the law offices of Irina Roller. Irina has dedicated her law practice to helping families obtain either appropriate public educational programs and services, or private school funding, for their children. She believes that every child can learn and flourish in the right learning environment, and with appropriate support. Irina and her staff work to ensure that children obtain the services and education they need, deserve and are entitled to by law.

Why New York Is One of the Best States for Medicare Beneficiaries

By Britt Burner and Brian Krantz

When it comes to Medicare, not all states are created equal. New York stands out as one of the most consumer-friendly states, offering benefits that don't exist elsewhere. New York is a "guaranteed issue" state, meaning it doesn't require medical underwriting to enroll in a Medicare Supplement plan. This gives New York Medicare beneficiaries unparalleled flexibility, allowing them to change insurance plans easily at any time. New York also has high-income limits for financial assistance programs and state-sponsored benefits. Programs such as The Elderly Pharmaceutical Coverage (EPIC) allow New Yorkers to save significantly on Medicare-related costs.

As an Elder and Special Needs lawyer in the state of New York, you likely have clients or potential clients who are eligible for Medicare. Understanding the basics of Medicare, how the program works in New York, and the various cost-saving initiatives, will be valuable in attracting and retaining clients by showing your deep knowledge of the services available to them at this stage of life.

Understanding Medicare Basics

Medicare is a federal health insurance program primarily for individuals turning 65, as well as those under 65 who qualify due to Social Security Disability Insurance (SSDI). While other circumstances may grant eligibility, these are the most common.

Medicare consists of two main components: Part A, which covers hospital-related services and skilled nursing facilities, and Part B, which covers doctor visits and outpatient medical care.

Unlike Parts A and B, which are administered by the federal government, Medicare Part D prescription drug plans are managed by private insurance companies. To enroll in a Part D plan, a beneficiary must have at least Medicare Part A, though having Part B is not required.

For individuals who receive Medicaid in New York before becoming eligible for Medicare, enrollment in a benchmark Medicare Part D plan happens automatically through a private insurer. This ensures that Medicaid recipients transitioning to Medicare do not lose prescription drug coverage.

One of the most common misconceptions about Medicare is that it is free. While Medicare Part A is premium-free for individuals (or their spouses) who have worked and paid Medicare taxes for at least 40 quarters (10 years), Medicare Part B requires a monthly premium. In 2025, the standard Medicare Part B premium is $185 per month. However, higher-income beneficiaries pay more due to the Income-

Related Monthly Adjustment Amount (IRMAA). Social Security determines your Medicare Part B premium based on your modified adjusted gross income (MAGI) as reported on your IRS tax return from two years ago.

For example,

- For individuals who earned less than $106,000 in 2023 (or $212,000 for joint filers), in 2025 they will pay the standard $185 per month.
- For those who earned over $500,000 in 2023 as an individual, or $750,000 as a couple, in 2025 will pay $628.90 per month for Part B, plus an extra $85.80 per month on top of their Medicare Part D premium.

Many beneficiaries who take no medications and do not want a Part D plan are surprised to learn that failing to enroll in a Medicare Part D prescription drug plan when first eligible results in a lifelong penalty. The penalty is 1% of the national average premium for each month without Part D or creditable coverage and remains for as long as the beneficiary is enrolled in Medicare Part D.

No Medical Underwriting: A Game-Changer for New Yorkers

One of the most important aspects of Medicare that beneficiaries should understand is the impact of medical underwriting. In almost every other state, medical underwriting is required to obtain a Medicare Supplement (Medigap) plan. This means that beneficiaries must pass a health evaluation to qualify, and in many cases they can be denied coverage.

Medical underwriting is a process used by insurance companies to evaluate an applicant's health history. Individuals can be denied coverage or face higher premiums if they have been recently hospitalized, diagnosed or treated for serious conditions, or advised by a doctor that they need an upcoming medical procedure. In most states, switching from a Medicare Advantage plan to a Medigap plan requires answering health-related questions, and failing underwriting could result in being denied coverage. Outside of New York, the best time to purchase a Medigap plan is during the Medigap Open Enrollment Period, which begins when an individual first becomes eligible for Medicare, either by turning 65 or enrolling in Part B. During this period, insurance companies cannot deny coverage or charge higher premiums based on health history.

New York, however, does not allow medical underwriting. This means that any applicant, regardless of their health history or pre-existing conditions, is guaranteed acceptance into a Medicare Supplement plan at any time. This policy ensures that individuals who develop health conditions later in life still have access to comprehensive coverage without fear of being denied.

Unlike in most states, where individuals must carefully time their plan changes to avoid being locked out of Medigap coverage, New Yorkers have the flexibility to adapt their Medicare coverage as their health care needs change. Many beneficiaries choose to enroll in a Medicare Advantage plan when they are healthy and then switch to a Medigap plan later if they require more comprehensive coverage.

While applicants cannot be denied coverage, insurance companies in New York may impose a waiting period for pre-existing conditions if the individual has gone without prior coverage before enrolling in a Medigap plan.

This consumer-friendly approach benefits Medicare beneficiaries, but it has also created challenges for insurance companies in New York. Since they must accept all applicants regardless of health status, many insurers have found it difficult to sustain the financial burden. As a result, some insurance companies have stopped selling Medicare Supplement plans in New York altogether, increased premiums significantly, or made the enrollment process more complicated.

Optimal Time To Switch to a Medicare Supplement Plan in New York

Timing is crucial when switching to a Medicare Supplement plan, as it must align with the ability to leave a Medicare Advantage plan. There are two main time frames when this can be done.

The annual enrollment period, from October 15 to December 7, allows individuals to switch from a Medicare Advantage plan to a Medicare Supplement plan, with the new plan taking effect on January 1. Additionally, the Medicare Advantage Open Enrollment Period (MA OEP), from January 1 to March 31, provides another opportunity to drop a Medicare Advantage plan and enroll in a Medicare Supplement plan, with the new coverage starting on the first day of the following month. In New York, no specific reason is required to make this switch – beneficiaries simply need to act within these designated periods.

Another critical factor to consider is prescription drug coverage. Because most Medicare Advantage plans include drug coverage, switching from a Medicare Advantage plan to either a new Medicare Advantage plan or a standalone prescription drug plan will automatically cancel the previous Medicare Advantage plan. However, Medicare Supplement plans do not include drug coverage. If a beneficiary switches from a Medicare Advantage plan to a Supplement plan but does not enroll in a standalone Part D prescription drug plan, their Medicare Advantage plan will remain active, making the Supplement plan ineffective. To avoid this, beneficiaries must ensure their Medicare Advantage plan is properly canceled when transitioning to a Supplement plan.

Special Enrollment Opportunities in New York

Special Enrollment Periods (SEPs) provide Medicare beneficiaries with the ability to make changes outside of standard enrollment windows. In New York, these periods offer an even greater advantage due to the state's no medical underwriting rule. One of the most important SEPs applies to individuals who are institutionalized in specific health care facilities.

Medicare Part A covers inpatient hospital care, including semi-private hospital rooms, meals, and nursing care. However, to qualify for skilled nursing facility (SNF) coverage under Medicare, beneficiaries must have been hospitalized as an inpatient for at least three consecutive days, not counting the discharge day. Additionally, the SNF stay must be directly related to the condition for which the patient was hospitalized. Medicare covers skilled nursing facility stays as follows:

- Days 1-20: Medicare covers 100% of costs with no coinsurance.
- Days 21-100: Beneficiaries are responsible for a daily amount of $209.50 for each day, which can be covered by a Medicare Supplement plan.

If a Medicare beneficiary moves into, resides in, or moves out of a skilled nursing facility, nursing home, intermediate care facility, rehabilitation hospital, or long-term care hospital with an expected stay of at least 90 days, they qualify for an Institutionalized SEP. This SEP begins on the first day of institutionalization and ends two months after discharge. During this period, individuals can enroll in a Medicare Advantage plan, drop it, and switch to a Medicare Supplement plan in New York without medical underwriting.

This SEP is particularly advantageous for Medicare beneficiaries in New York, as it provides a level of flexibility that is not available in most other states. Many institutionalized facilities actively encourage patients to transition away from Medicare Advantage plans in favor of traditional Medicare with a Supplement plan. This is because Medicare Advantage plans often require beneficiaries to pay daily copayments for their stay and place restrictions on the length of time they can remain in a facility. By switching to traditional Medicare with a Supplement plan, beneficiaries gain more freedom, and their coverage is often more comprehensive. Not only does this allow patients to stay in facilities longer and receive the care they need, but it also ensures that facilities are properly compensated for the services they provide.

How Medicare and Medicaid Work Together in New York

Medicare serves as the primary payer, covering hospital care under Part A and medical services under Part B. Medicaid acts as the secondary payer, covering Medicare deductibles, coinsurance, and copayments. In many cases, Medicaid also helps cover services that Medicare does not provide, such as long-term care. However, Medicaid programs vary by

state, and while some states may use different names, all have programs designed to assist low-income individuals.

Individuals who qualify for both Medicare and Medicaid are known as dual eligibles. These beneficiaries also have the option to enroll in Dual Eligible Special Needs Plans (D-SNPs), which are Medicare Advantage plans specifically designed for those who qualify for both programs. These plans are heavily marketed because they allow insurance companies to generate revenue while also helping clients coordinate their benefits.

D-SNPs integrate Medicare and Medicaid services, streamlining care management, improving coordination, and reducing administrative burdens for beneficiaries. Many dual-eligible individuals face challenges related to housing instability, food insecurity, and transportation issues, and D-SNPs often provide additional support services to address these needs.

To attract enrollees, insurance companies offer extra benefits beyond traditional Medicare, including dental, vision, and hearing coverage, transportation services, and over-the-counter (OTC) benefit cards that can be used for food, health products, and personal care items. Prescription drug coverage is also included, often reducing medication costs to minimal amounts.

Medicare Savings Programs in New York

Medicare Savings Programs (MSPs) are state-administered programs that assist low-income individuals in paying their Medicare premiums. New York has some of the most lenient MSP qualifications in the country, making these programs accessible to a larger population. In 2023, the state expanded MSP income eligibility from 135% to 186% of the Federal Poverty Level (FPL), making an estimated 300,000 additional New Yorkers eligible for assistance.

When an individual qualifies for an MSP, they automatically receive Extra Help, a federal program that reduces Medicare Part D prescription drug costs. The New York State Department of Health has designated local Departments of Social Services as the primary administrators of MSP benefits.

New York offers two primary MSP categories:

- Qualified Individual (QI): Income limit of $2,426 (single) or $3,279 (couple).
- Qualified Medicare Beneficiary (QMB): Income limit of $1,800 (single) or $2,433 (couple).

Unlike many other states, New York does not impose an asset limit for MSP eligibility – qualification is strictly based on gross monthly income. Gross Social Security income is counted before the Part B premium deduction, and other health insurance premiums, such as Medigap or dental plans, can be deducted from income.

“EPIC is a New York State-specific prescription assistance program that supplements Medicare Part D costs for income-eligible seniors aged 65 and older.”

Key benefits of the MSP program include:

- Paying the Medicare Part B premium, saving beneficiaries $2,220 annually.
- Automatic qualification for Part D Extra Help.
- Elimination of the Part B Late Enrollment Penalty.
- Allowing Part B enrollment outside of standard periods.
- QMB also covers the Part A premium for individuals who do not have enough work history for free Part A.

The Elderly Pharmaceutical Insurance Coverage (EPIC) Program

EPIC is a New York State-specific prescription assistance program that supplements Medicare Part D costs for income-eligible seniors aged 65 and older. Unlike many other states, New York allows seniors to apply for EPIC at any time during the year, provided they are enrolled in a Medicare Part D drug plan. The application process has some of the highest income thresholds in the country for a State Pharmaceutical Assistance Program (SPAP), making it easier for New Yorkers to qualify.

EPIC offers two plan options:

- Fee Plan: Available for individuals earning up to $20,000 (single) or $26,000 (married).
- Deductible Plan: Available for individuals earning up to $75,000 (single) or $100,000 (married).

EPIC does not replace Medicare Part D but instead helps cover the cost of prescriptions by reducing out-of-pocket expenses on a sliding scale. Beneficiaries receive an EPIC card, which must be presented alongside their Part D plan when filling prescriptions.

Enrollment in EPIC provides an additional election period per year to switch a Medicare Advantage or Part D plan. The new plan takes effect the month following the application's receipt. If an individual loses their SPAP eligibility, they qualify for another Special Enrollment Period (SEP), which begins the month of notification and ends two months later.

Inflation Reduction Act: Key Medicare Changes in 2025 and the $2,000 Cap on Drug Costs

One of the most significant policy changes impacting Medicare beneficiaries is the Inflation Reduction Act. This legislation introduced several key reforms aimed at reducing out-of-pocket prescription drug costs under Medicare Part D.

In 2024, cost-sharing in the catastrophic phase of Part D was eliminated, meaning beneficiaries no longer have to pay out-of-pocket once they reach this stage.

In 2025, a new $2,000 annual out-of-pocket cap for Medicare Part D beneficiaries takes effect. This cap is a major relief for those with high prescription drug costs, as it ensures that once a beneficiary spends $2,000 on covered medications, they will not have to pay anything further out-of-pocket for the rest of the year. However, this cap does not apply to drugs that are not covered under a Part D plan, medications covered under Part B (such as infused drugs administered in an outpatient setting), or monthly premiums.

While this reform benefits those with high prescription drug expenses, it has also had unintended consequences. Many insurance companies have increased Part D plan premiums to compensate for the new cap, and some have consolidated or eliminated plans entirely. As a result, many beneficiaries – especially those who take few or no medications – have questioned why they are required to enroll in a Part D plan when they may see little immediate benefit.

New York's Unique Medicare Benefits: Maximizing Coverage and Savings

New York's consumer-friendly policies, including its no medical underwriting rule, lenient MSP qualifications, and EPIC program, make it one of the most advantageous states for Medicare beneficiaries.

The ability to switch Medicare Supplement plans at any time without medical underwriting ensures that individuals can adjust their coverage as their health care needs change, even with pre-existing conditions. The state's Medicare Savings Programs offer premium assistance with some of the highest income limits in the country, making coverage more affordable for many. The EPIC program provides additional prescription drug cost relief for middle-income seniors while allowing for an extra plan switch each year. Skilled nursing facilities often favor Medigap plans over Medicare Advantage, as they allow for longer covered stays with fewer restrictions.

Additionally, the Inflation Reduction Act introduces a $2,000 cap on Medicare Part D drug costs, which provides significant savings for beneficiaries with high prescription expenses. However, the law has also contributed to higher premiums for some plans.

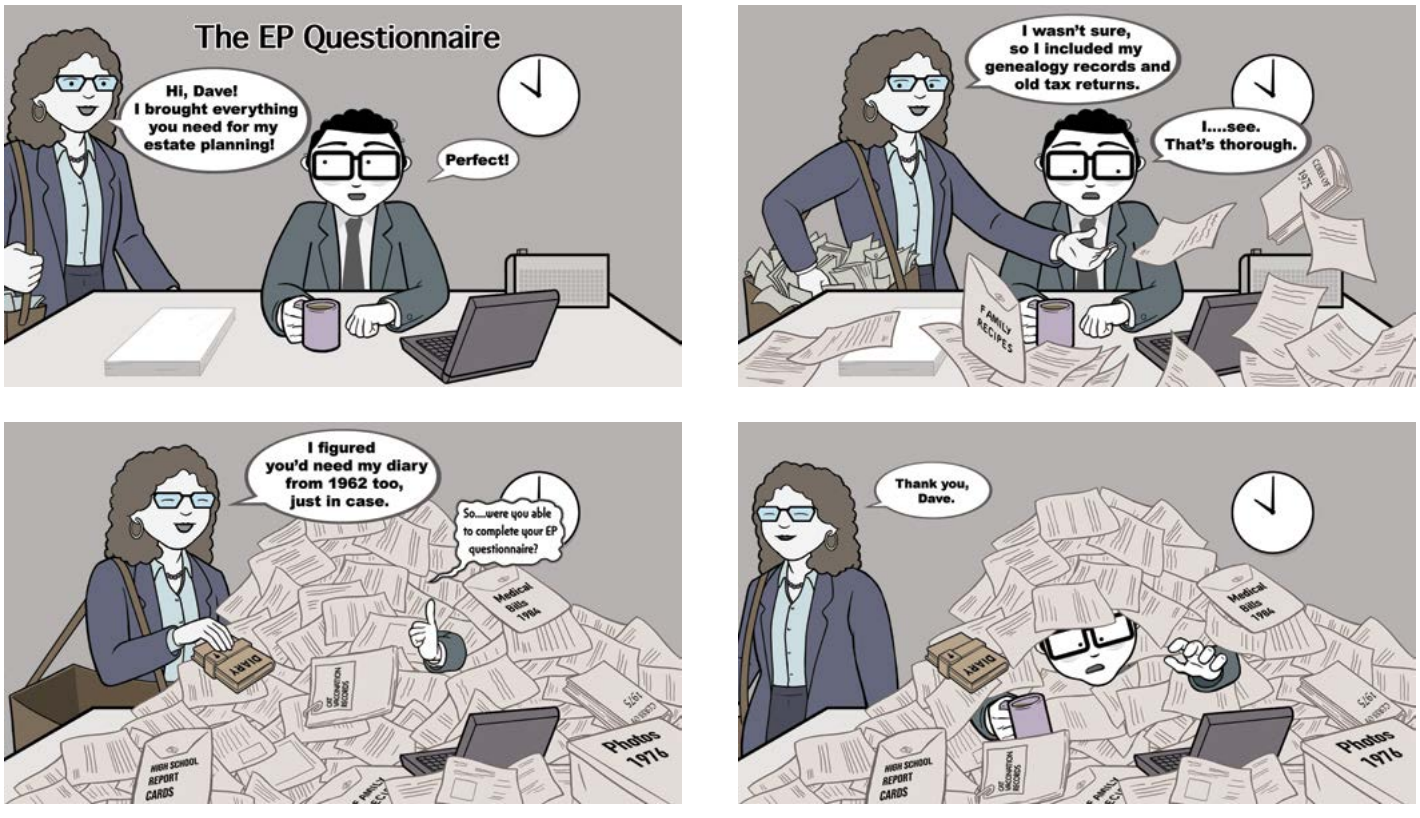
Medicare is a very complex, confusing topic. Seniors who are 65+ or approaching Medicare eligibility are likely uneducated on their options and overwhelmed by the noise and information available to them. As an Elder and Special Needs lawyer, you have the opportunity to share critical information and reiterate that beneficiaries in the State of New York, in particular, have unparalleled access to great coverage, with a variety of ways to reduce associated costs.

Brian Krantz is a leading Medicare advisor with over 15 years of experience helping individuals navigate the complexities of Medicare. Based in New York and licensed in all 50 states, Brian specializes in Medicare Supplement (Medigap), Medicare Advantage and prescription drug plans, ensuring his clients maximize their coverage while minimizing costs. He has worked with thousands of beneficiaries, including professionals, retirees, and those transitioning from employer-sponsored plans. Brian is committed to simplifying Medicare and providing clear, unbiased guidance to help clients make informed decisions. You can read more about Brian and his company at www.planmedicare.com

Britt Burner is a partner at Burner Prudenti Law, P.C. with offices in Manhattan, East Setauket, Westhampton Beach, and East Hampton. She is an active leader in the legal community, currently serving as chair of the Elder Law and Special Needs Section of the New York State Bar Association. She also serves as a charter member of the Advisory Council of the Katz Institute for Women's Health at Northwell.

A Comic Strip by
Antony M. Eminowicz,

KINGSTON, NY



Member Spotlight: Robert Arbuco

Q: Where are you from?

A: I am from West Nyack, New York in Rockland County.

Q: Where is your favorite place you have traveled to?

A: My favorite city in the world is Venice, Italy, mostly because of how unique it is. As a whole, I loved Italy and had the amazing opportunity to study there for two months.

Q: What led you to work in the field of elder law?

A: The elder law field will never lack demand, especially as our elder community population rates continue to rise. In order to help that large portion of the population, I sought work in the field of elder law, beginning with working as a Law Clerk at Enea, Scanlan & Sirignano, LLP, during my second year of law school.

Q: Did you have a turning point in your career?

A: A major turning point in my career occurred when my son was born in 2024. My perspective changed and I now emphasize the importance of being reliable and dependable. Working for the sake of others is a valuable motivator.

Q: What is your favorite part about your job?

A: The best part about my job is aiding individuals and families with navigation of the complicated, high stakes fields of Medicaid planning and Estate Planning. It is great helping to preserve assets for hard-working individuals and families in need of legal assistance.

Q: Tell me about an accomplishment that you consider to be the most significant in your career thus far.

A: The most significant accomplishment in my career thus far is becoming an Associate Attorney at Enea, Scanlan & Sirignano, LLP. The firm's offer served as an affirmation that in my time as a Law Clerk, I demonstrated the ability to become a dedicated attorney in elder law. Since then, I have been able to develop in the practice area and network throughout Westchester County.

Q: Where do you see yourself in 5 years?

A: In 5 years I see myself continuing to expand my knowledge and grow throughout the field of elder law. I will also maintain the drive to grow a client base and serve the elderly population.

Q: What did you want to be when you were younger?

A: When I was younger, I unrealistically wanted to be the first baseman for the New York Yankees. However, I did also want to be a police officer like my father. As I continued through my undergraduate career, I began planning to become an attorney.

Q: Tell me a little about your family.

A: I grew up in a large family with four other siblings, along with two loving parents. My wife, Alexandra, and I met when we were at the University of Arizona over ten years ago. We married in 2019 and had our first child (Charles) in 2024. We love being parents to our baby boy!

Q: Are there hobbies you look forward to outside of work?

A: When I am not at work, I enjoy attending concerts and sports games. I also love reading, playing guitar, spending time with my family, and completing projects at home. Playing with my son has become my favorite hobby!

Q: Do you have any advice to give?

A: My advice to newer attorneys: with the world shifting further into an age of digital outreach, do not forget the importance of in-person meetings and networking.

Robert Arbuco, is an Associate at Enea, Scanlan & Sirignano, LLP. He focuses his practice on Estate Planning, Elder Law and Medicaid Planning and Applications. He is a member of the New York State Bar Association Elder Law Section Medicaid Committee, the Westchester County Bar Association New Lawyers Section and the Columbian Lawyers Association of Westchester. He can be reached at R.Arbuco@esslawfirm.com

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Memorandum in Support

March 3, 2025

S. 4786 By: Senator Skoufis
A. 1907 By: M. of A. Paulin
Senate Committee: Health
Assembly Committee: Health
Effective Date: Immediately

The New York State Bar Association's Elder Law and Special Needs Section ("ELSN") supports A1907/S4786, which would eliminate a look-back period for Community Medicaid applicants seeking long term care services provided in their home and asks that this language be included in the Assembly and Senate's one house budget bills. The 30-month look-back, coupled with its implementation delay, is creating significant public confusion, increasing pressure on already overburdened spouses and caregivers.

The imposition of a 30-month look-back for Community Medicaid applicants was passed in the 2019-2020 Legislative session. However, it has not been implemented, at least partially, because of federal COVID protections that are now being lifted, which could allow implementation this year. There are a number of reasons compelling repeal of the 30-month look-back, which include: (1) the large administrative implementation price tag for only modest expected savings; (2) the delay it will cause for qualified New Yorkers to access necessary services; (3) the overloading of hospitals and nursing homes that it will cause; and (3) the violation of *Olmstead*, which enforces the Americans with Disabilities Act, requiring States to offer community-based services for the disabled in the least restrictive setting.

Significant Cost for Only Modest Savings. When originally enacted, the State projected only modest Medicaid state savings for the look-back-- $5.5 million in 2021 and $11.75 M in 2022. (MRT II Executive Summary Scorecard).[1] According to DOH's 1115 Waiver, a mere 3,800 applicants per year were expected to be subject to a transfer penalty if the 30-month look-back was implemented. With the increased asset limit which took effect in 2023, this number is likely significantly smaller. The asset limit was approximately $15,000 per person when this look-back was initially passed but has since been doubled to over $30,000. With a $10,000 average transfer for which a penalty is expected to be imposed,[2] under the higher asset limit, many of these 3,800

[1] Comment on transfer of a home at: https://health.ny.gov/health_care/medicaid/redesign/mrt2/proposals/30-month_look-back-final.htm#_bookmark2.

[2] New York State Medicaid Redesign Team 1115 Research and Demonstration Waiver – 30 Month Look Back for Community Based Long Term Care Services Amendment Request at: https://www.health.ny.gov/health_care/medicaid/redesign/mrt2/proposals/docs/30-month_lookback.pdf

people would now qualify for Medicaid without making any transfer of assets. The result of this would be a reduction, if not total elimination, of any expected savings. Moreover, these projections failed to take into account the costs of implementation to the State as well as local districts. The implementation will create a massive burden on the system with extensive paperwork collection and reviews, at a time when they are grossly understaffed.

Any savings are also offset by costs to hospitals and rehabilitation facilities that will be unable to discharge patients safely and expediently with proper home care, thus causing increased costs for Medicaid coverage of hospital stays as detailed below.

Delays in Access to Services for All Applicants. Unlike the longstanding look-back for nursing home care, when applied to community-based care, the look-back will cause severe delays in access to services. These delays will harm all applicants, most of whom are poor and have no assets to transfer -- pushing many into a hospital or nursing home.

Since an individual may only apply for nursing home Medicaid after being admitted to a nursing home, delays while DSS reviews financial records in a look-back review do not prevent a nursing home resident from receiving appropriate care. In contrast, a consumer who applies for Medicaid to cover home care services is not eligible to receive any Medicaid services until the application is approved and then not until they are assessed and enroll in an MLTC plan. Services rarely begin until 3-5 months after filing the Medicaid application. The local DSS agencies are already backlogged, taking months longer than the 45-day time limit mandated by federal regulations to act upon a Medicaid application. 42 USC 1396a(a)(8)(requiring assistance to be provided with "reasonable promptness"); 42 C.F.R. Sec. 435.911. The MLTC assessment and enrollment process add on several more months of delay.

A 30-month look-back will inevitably protract the application process to 6 months or more. During that time the applicant receives no Medicaid services at all. While the look-back is intended to block the few who transferred assets from accessing Medicaid services, the resulting delays harm the majority of applicants whose assets are eligible without a transfer of assets. They may have to go without needed services for as much as a year, while the application is pending, pushing many into a hospital or nursing home. The risk of nursing home placement will fall disproportionately on low-income communities and BIPOC communities, who are less likely to have retirement funds or other resources to privately pay for home care while waiting for Medicaid. These are often families who have tried to do the right thing and spend down to the Medicaid asset limit only to now be faced with months of new delays in receiving services.

Hospital Overload. The 30-month look-back will also negatively affect and quickly impact already overloaded hospitals, impeding the ability to effectuate safe discharge plans that require

Medicaid home care. Those individuals who are discharged without access to needed care at home may suffer falls or other episodes that result in what could have been an avoidable re-hospitalization. The delays will also contribute to overpopulation in nursing homes and rehabilitation facilities. All these institutions are facing their own workforce pressures to meet current demand for services.

Violation of *Olmstead.* The 30-month look-back violates the U.S. Supreme Court's decision in *Olmstead*, which requires States to offer community-based services for the disabled in the least restrictive setting. *Olmstead v. L.C.*, 527 U.S. 581 (1999). Although *Olmstead* does not require a state to have a community-based program without a lookback, it does prohibit a state from altering or modifying its existing program to make it more restrictive, which this law clearly does.

States cannot discriminate against people with disabilities by offering them long-term care services only in institutions when they could be served in the community, given State resources and other citizens' long term care needs. The ADA's implementing regulations contain its community integration mandate, which requires state and local governments to "administer services, programs, and activities in the most integrated setting appropriate" to the needs of people with disabilities. 28 C.F.R. § 35.130(d). The regulations also require state and local governments to make reasonable modifications to policies, practices, and procedures to avoid disability-based discrimination, unless such modifications would fundamentally alter the nature of the service, program, or activity. As described above, the look-back will push people into nursing homes where they can access institutional care while the look-back review is conducted but cannot access home care during the look-back review in an application for community-based care.

For the above reasons, NYSBA's Elder Law and Special Needs Section **SUPPORTS** the repeal of the 30-month look-back and requests that the repeal as stated in A1907/S4786 be included in the Assembly and Senate's one house budget bills.

New York State Bar Association
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Memorandum in Support

March 3, 2025

Effective Date: 180th Day

BUDGET BILL: S.3008/A.3008 – Part AA l

LAW AND SECTIONS REFERRED TO: General Business Law, Banking Law, Social Services Law

INTRODUCTION

The New York State Bar Association's Elder Law & Special Needs Section ("ELSN") supports S.3008/A.3008 – Part AA l (Protecting Eligible Adults From Exploitation) of the Transportation, Economic Development, Environmental Conservation Article VII bill, which amends sections of the Banking, General Business, and Social Services Laws to protect eligible adults from financial exploitation. ELSN commends the Governor for continuing to include this issue as part of the Executive budget and is strongly supportive of the Executive's proposed language, which is largely consistent with proposals previously advanced by ELSN. We offer the following suggestions to provide additional protection to the state's most vulnerable population against financial abuse, while ensuring proper due process protections.

1. Application and Duration of Transaction Holds; Notice to Be Provided

ELSN supports the Executive's proposed language regarding the application of transaction holds. If it is reasonably believed that financial exploitation has occurred, a transaction hold can be placed on such transaction. This language will allow for continued payment of prearranged charges and other expenses that may need to be paid while an investigation is pending. Additionally, the eligible adult can still have access to cash during this time to pay for groceries or other incidentals.

ELSN supports setting the transaction hold at fifteen business days after its application, with the ability for financial institutions to extend the hold for up to forty additional days if there is a continued reasonable belief of exploitation, ELSN also agrees with the included exceptions stated in the proposed language. To ensure appropriate due process, the language should require notice to interested parties authorized to transact business on the account in question. Should a court decide to prolong the transaction hold, notice shall be given to the principal account holder, the alleged exploiter and the proposed recipient of the fund that the establishment of specific procedures to ensure that proper investigation has been conducted before extending a transaction hold or releasing it, affords maximum protection of an eligible adult. It is important to stress that the notice should be provided to all interested parties. We suggest including the "eligible adult" as

defined in the proposed language, in the legislation in order to acknowledge the due process rights of the account holder.

Recognizing that these sections require that notification be made in writing, we believe that specific guidelines should be established for such notice to be implemented. The purpose of the notice requirements are integral to affording real protection to the eligible adult, as such notice serves to alert interested parties that there may be incidents of financial abuse. Moreover, implementation of notice requirements among the banking and financial institutions must be consistent to be effective. Additionally, to protect the constitutional due process rights of eligible adults, the proposal should incorporate specific procedures for providing notice, including service of said notice upon the parties affected, and other forms of follow-up communication, such as telephone calls or electronic communications. Since the financial and banking institutions have broad discretion to place a transaction hold, the account holder has the right to know if this is being done. ELSN recommends the following insertion to the Executive's proposal to achieve that goal:

> *Notice shall be made by the following methods: (A) personal delivery or overnight delivery service to all parties authorized to transact business on the account for which the transaction hold was placed and (B) telephone, text, email message or other electronic communication medium to all parties that provided contact information, and multiple notice attempts if the bank does not receive confirmation that the foregoing notice has been received.*

2. Reporting Requirements When a Transaction Hold has been Initiated

There must be specific guidelines regarding mandatory reporting by banks and financial institutions to adult protective services or a law enforcement agency. ELSN supports establishing reporting requirements in conjunction with the amended Section 352(m) Section 3(a) of the General Business Law and the proposed new section 4-d(2)(a) of the Banking Law, authorizing an employee of a banking or financial institution to place a transaction hold on a particular transaction if there is reasonable belief of financial exploitation. With respect to Sections (c)(ii) and (iii) under both the General Business Law and the new proposed section of the Banking Law, we support the following provisions, but recommend that mandated reporting should be no less than one business day:

- Mandated reporting no less than one business day.
- Reporting of basis for belief that the transaction is the subject of financial exploitation.
- Report to adult protective services and law enforcement.
- Upon request by adult protective services or law enforcement, information and documents must be provided within three business days.

3. Training and Education

To ensure continuity of training and education in addressing issues of financial exploitation, specific guidelines need to be required. Accordingly, we propose the following additional language:

Training and education. 1. The superintendent, in consultation with the director of the office for the aging, the director of the bureau of adult protective services within the office of children and family services, the commissioner of the office of people with developmental disabilities and the director of the office of victim services, shall develop a financial exploitation training and education program for banking institutions as defined in section four hundred seventy-three of the social services law. The superintendent shall also consult with elder advocacy groups and disability rights organizations that possess specialized knowledge in the prevention and/or identification of financial exploitation, advocacy groups that possess specialized knowledge in developmental disabilities, diseases and other conditions that may impair mental and cognitive function, instructors from organizations that provide services to vulnerable elderly persons that may have experience in identifying financial exploitation, and organizations that provide services to individuals with developmental disabilities.

2. Participation in the financial exploitation training and education program shall be voluntary by the banking institution and the superintendent shall not require, by regulation of otherwise, that any director, officer or any other person affiliated with a banking or institution, participate in or attend such training and education program.

3. The financial exploitation training and education program shall be designed to provide information, training and education on how to identify, help prevent and report the financial exploitation of a vulnerable elderly person as defined in section 260.31 of the Penal Law.

4. The superintendent shall make the materials and instruction of the financial exploitation training and education program available to all banking institutions across the state at no cost, and shall further make such available via both live instruction platforms as well as through online instructional presentations accessible through the websites of the department, the office for the aging, the office of children and family services, the office of people with developmental disabilities and the office of victim services.

5. Each banking institution shall have policies and procedures in place for the banking institution to make the notification required under Subsection 9(e)(i); and for the banking institution to place the temporary account hold and submit the report required under Subsection 9(e)(ii) of Section 473 of the social services law. The policies and procedures adopted under this Subsection shall include language that the banking institution may report the suspected financial exploitation to other appropriate agencies and entities in addition to the department, including the attorney general, the Federal Trade Commission, and the appropriate law enforcement agency.

4. Immunity

ELSN supports the inclusion of the immunity protections for a banking or financial institution that places a transaction hold in good faith. We suggest incorporation of the language which appeared in last year's budget bill, to wit:

> *Immunity: a broker-dealer, investment advisor, or a qualified individual shall be immune from criminal, civil and administrative liability for good faith actions in relation to the application of this section, including any good faith determination to apply or not to apply a transaction hold to a transaction. Notwithstanding, such immunity shall not apply to a determination not to impose a transaction hold when the broker-dealer, investment advisor, or qualified individual engages in intentional misconduct in making the determination or if the determination results in a conflict of interest.*

5. Social Services Law Amendments

The amendments to the Social Services Law would establish important guidelines for social services officials to report information that financial exploitation has occurred to appropriate law enforcement agencies and to notify a financial or banking institution involved in the relevant financial transactions of the need to apply a transaction hold. Including this section will provide additional protection to vulnerable elderly adults so that even if a financial or banking institution is not yet aware of financial exploitation, a transaction hold can be applied based upon notification from the proper authorities.

For the above reasons, the New York State Bar Association Elder Law and Special Needs Section SUPPORTS Part II of S.8308/A.8808 and respectfully requests consideration of ELSN's detailed recommendations.

New York State Bar Association
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Memorandum in Support

March 3, 2025

S. 358 By: Senator Rivera
A. 1198 By: M. of A. Paulin
Senate Committee: Health
Assembly Committee: Health
Effective Date: Immediately

THE ELDER LAW AND SPECIAL NEEDS SECTION SUPPORTS REPEALING ADDITIONAL ACTIVITY OF DAILY LIVING (ADL) REQUIREMENTS FOR PERSONAL CARE and CDPAP SERVICES

During the height of the pandemic, as a result of recommendations from the Medicaid Redesign Team II, the then-Executive pushed through as part of the 2020-2021 New York State Budget (Chapter Law 56, Part MM Sections 2- a and 3), amendments to NY SSL Sections 365-a and 365f. These changes restricted eligibility for Medicaid personal care and consumer-directed personal assistance program (CDPAP) services as well as for enrollment in Managed Long Term Care (MLTC) plans in New York State to persons who require "limited assistance with physical maneuvering with more than two activities of daily living, or for persons with a dementia or Alzheimer's diagnosis, as needing at least supervision with more than one activity of daily living, provided that the provisions related to activities of daily living in this paragraph shall only apply to persons who initially seek eligibility for the program on or after October first, two thousand twenty."

S.358 (Rivera)/A.1198 (Paulin) repeals the additional activity of daily living (ADL) requirements for Personal Care Services. This repeal is critical to ensure that vulnerable persons who need assistance have access to crucial home care services that prevent accidents, deterioration in health conditions, and unnecessary hospitalization and institutionalization. This equal access to home care for all individuals in need of home care services is necessary to prevent discrimination based on disability in violation of the Americans with Disabilities Act and the federal Medicaid laws and regulations.

New York State law does not explicitly define "activities of daily living" (ADL), but the Federal Center for Medicare & Medicaid Services (CMS) State Medicaid Manual defines ADLs to "include eating, bathing, dressing, toileting, transferring, and maintaining continence." The CMS State Medicaid Manual defines Instrumental Activities of Daily Living (IADLs) to "include personal hygiene, light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication management, and money management." In New York, IADLs are classified as "nutritional and environmental support functions" or maintaining "Level 1" or "housekeeping" tasks, as differentiated from "Level II" personal care tasks or ADLs. NY SSL Sections 365-a, subd. 2(e)(iv); 18 N.Y.C.R.R. § 505.14(a)(v).

In 2020, there were two key changes to the criteria for qualifying for Medicaid personal care or CDPAP– setting a minimum *number* of ADLs to qualify for any personal care or CDPAP assistance and requiring a minimum *level* of assistance with these ADLs to qualify for home care.

The threshold number of ADLs and threshold level of assistance required is lower for people with dementia or Alzheimer's disease. In order to prevent illegal discrimination based on diagnoses, it is imperative to repeal the categorizations of people who qualify for services based on diagnosis For the first time, State law sets a minimum number of ADLs for which an individual must need assistance in order to qualify for *any* personal care or CDPAP services.

These numerical requirements represent an enormous restriction, as personal care and CDPAP services for many decades have been available to persons who needed *any* assistance with an ADL, with the amount of service dependent on individual need. Prior to enacting the MRT II proposal, even those who could independently perform ADLs, but who needed support with "nutritional and environmental support functions" (IADLs like shopping, cooking, cleaning, or doing laundry), were eligible for a maximum of eight hours per week of personal care services. NY SSL Sections 365-a, subd. 2(e)(iv).

Now, because of the ADL minimum requirement, eligibility for the limited eight hours of weekly IADL assistance has been eliminated, thus depriving vulnerable persons of a vital preventative service that enabled them to stay in their homes and communities, and to avoid accidents, injury, deteriorated health conditions, and institutionalization.

In order for an ADL to be counted toward the minimum threshold number, an individual must need "at least limited assistance with physical maneuvering" with three ADLs, with the exception that a person with a dementia or Alzheimer's diagnosis must be "assessed as needing at least supervision with" two ADLs. NY SSL Sections 365-a, subd. 2(e)(v). Requiring "supervision" with two ADLs is not only a lower threshold than requiring "physical maneuvering" with three ADLs, it acknowledges the distinctive *type* of assistance specifically needed by people with cognitive impairments. In discussing the scope of personal care services, the CMS Medicaid Manual, *supra*, describes the cueing or supervisory assistance needed by people with cognitive impairments who may be physically capable of performing ADLs and IADLS.

> *Cognitive Impairments*.--An individual may be physically capable of performing ADLs and IADLs but may have limitations in performing these activities because of a cognitive impairment. Personal care services may be required because a cognitive impairment prevents an individual from knowing when or how to carry out the task. For example, an individual may no longer be able to dress without someone to cue him or her on how to do so. In such cases, personal assistance may include cuing along with supervision to ensure that the individual performs the task properly.

CMS Medicaid Manual, *supra*, n 1 at section 4480. Clearly, people with diagnosis of dementia and Alzheimer's disease are among those who have "cognitive impairments" who may need cueing rather than physical assistance with a task. But there are others as well. The U.S. Center for Disease Control (CDC) states, *"*Cognitive impairment is not caused by any one disease or condition, nor is it limited to a specific age group. Alzheimer's disease and other dementias in addition to conditions such as stroke, traumatic brain injury, and developmental disabilities, can cause cognitive impairment." Moreover, people who have vision impairments may need cueing assistance, especially if they became blind later in life, as is true for many older people with glaucoma or macular degeneration.

This repeal is necessary in order to eliminate the categories of diagnoses that qualify an individual for personal care. Otherwise, the restriction that allows only people diagnosed with Alzheimer's disease or dementia to qualify based on the need for supervisory assistance is discriminatory.

The minimum ADL requirements enacted as part of the 2020-2021 Budget appeared to be an attempt to align the Medicaid criteria for personal care with the U.S. Tax Code's definition of a qualified long term care insurance policy. See 26 U.S.C. § 7702B. However, the tax code expressly permits coverage for people who require assistance with two out of six ADLs, *or* who "[require] substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment." 26 U.S.C. § 7702B (c)(2)(A)(iii). Thus for people with a cognitive impairment, there is no minimum number of ADLs required to benefit from the tax benefits of a qualified long term care policy – provided that they need substantial supervision.

Though enacted in 2020, this ADL restriction has not yet been implemented because the American Rescue Plan Act ("ARPA") prohibited states from placing any new requirements or restrictions on the Medicaid program's home and community based services -- known as the "Maintenance of Effort" requirement. However, CMS is expected to sign off that New York has spent its ARPA funds, allowing implementation to go forward in 2025.

Notwithstanding the then-Executive's assertions, no savings have been, or will be, achieved as a result of this onerous and discriminatory standard. The projected savings must be offset by increased costs of hospital and nursing home admissions that would be avoided with preventative home care eliminated by the 2020 law. Moreover, New York could lose $500 million/year in an enhanced federal Medicaid match for the Community First Choice Option (CFCO), a federal Medicaid option under the Affordable Care Act that New York adopted. Soc. Serv. Law § 365-a, subd. 2(bb). NYS has drawn down $3.6 billion in the enhanced federal match since 2016. Many applicants who fail the new ADL test will nevertheless qualify for CFCO services because they have a "nursing home level of care" and live in the community, even if they fail the new ADL test. The State risks losing this funding if it denies eligible individuals CFCO services, which include both cueing and physical assistance with ADLs and IADLs.

Based on the foregoing, the Elder Law and Special Needs Section **SUPPORTS** ***S.358(Rivera)/A.1198(Paulin.***

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ELSN #6 March 25, 2025

ELDER LAW AND SPECIAL NEEDS SECTION

Memorandum in Support of the Senate's Rejection of the Governor's Nursing Home Transition Diversion (NHTD) Enrollment Cap

The Elder Law and Special Needs Section ("ELSN") of the New York State Bar Association **SUPPORTS** the Senate's Budget provision that serves to continue to reject the Executive Budget Proposal for a "hard enrollment cap" on the NHTD Waiver program, which currently serves approximately 7,300 New Yorkers.

ELSN is gravely concerned that while the proposed budget action may give the state an identified budget amount, it does not give the flexibility needed to resolve the state's requirement to maintain cost-neutrality; a requirement to keep the program compliant with Federal requirements. As the growth in the program is a result of the aging population in New York and the care needs of the population that can only be uniquely served by the NHTD waiver, it will shift the costs that would have otherwise been spent through the NHTD Waiver program to other Medicaid programs (likely nursing homes), while it creates barriers to accessing services that are only available within the waiver. Effectively, the budget's proposed cap will present considerable challenges and obstacles to the program and the population it serves while not solving the larger issue of overall cost containment within Medicaid as a whole.

We urge the New York State Department of Health to work collaboratively with the NHTD Waiver community to ensure that the program, which has been successful for almost 20 years, remains stable and available for years to come. Through other means, we believe there are solutions that consider both the cost-neutrality issue and the increasing overall cost of the program driven by the growing aging population in New York.

For the above reasons, NYSBA's Elder Law and Special Needs Section **SUPPORTS** the Senate's one house bill to continue to omit the Executive Budget Proposal for a "hard enrollment cap" on the NHTD Waiver program.

NEW YORK STATE BAR ASSOCIATION
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Memorandum in Support

ELDER LAW AND SPECIAL NEEDS SECTION

ELSN #5 March 25, 2025

S. 3007-B (Senate HMH One-House)
S. 3554 By: Senator Cleare
A. 1043 By: M. of A. Kim
Senate Committee: Finance (one-house)/ Health
Assembly Committee: Health
Effective Date: This act shall take effect January 1, 2026; provided, however, that the effectiveness of sections one and two of this act shall be subject to federal financial participation; provided, further, however, that the commissioner of health shall notify the legislative bill drafting commission upon the occurrence of federal financial participation in order that the commission may maintain an accurate and timely effective data base of the official text of the laws of the state of New York in furtherance of effectuating the provisions of section 44 of the legislative law and section 70-b of the public officers law. Effective immediately, the addition, amendment and/or repeal of any rule or regulation necessary for the implementation of this act on its effective date are authorized to be made and completed on or before such effective date.

AN ACT to increase the amount of the savings exemption for eligibility for Medicaid for individuals who are age 65 and older, blind, or disabled ("ABD").

LAW AND SECTIONS REFERRED TO: Subparagraph 4 of paragraph (a) of subdivision 2 of Section 366 (5) (e) of the New York SSL.

ELDER LAW AND SPECIAL NEEDS SECTION SUPPORTS THIS LEGISLATION

The New York State Bar Association's Elder Law and Special Needs Section ("ELSN") supports new Part ZZ of the Senate one-house bill that incorporates S3554/A1043, which would increase the asset test to $300,000 for individuals in the "ABD" category, meaning Aged 65+, Blind or Disabled. This category is also known as the "Non-MAGI" category, meaning those adults who

are not covered by the Affordable Care Act ("ACA") that uses "MAGI" budgeting. The current asset limit is $32,396 for singles and $44,781 for married couples in 2025.

Older New Yorkers and people with disabilities in the "non-MAGI" category are subject to a strict asset test to qualify for Medicaid, unlike all other adults in New York who are in the "MAGI" category, who have no asset limit. This bill would increase the "non-MAGI" asset test. This would ensure continuity of coverage for those who age or "disable" into the non-MAGI group, and bring greater equity to the Medicaid program by reducing health disparities for communities of color, who are disproportionately harmed by the current asset test. Increasing the asset limit to $300,000 would align with the increased assets allowed under the Medicaid Buy In for Working People with Disabilities (MBI-WPD) enacted in FY24 budget. Approval of the increase for MBI-WPD is pending with CMS.

Continuity of Coverage. Increasing the asset test would ease administrative burdens and ensure continuity of coverage when people receiving Medicaid under the ACA -- which has no asset limit -- become eligible for Medicare upon turning 65 or on receiving Social Security Disability benefits for two years. At that point, they become subject to strict asset limits, causing many to lose Medicaid. By increasing the asset limit, many will be able to retain Medicaid as secondary coverage to fill in the gaps not covered by Medicare.

Lessen Discrimination against BIPOC Communities. Older New Yorkers and people with disabilities with monthly incomes below 138% of the Federal Poverty Line ($1800/month in 2025) are disproportionately Black, Indigenous and People of Color (BIPOC), and are particularly harmed by the current asset test. The savings people at this income level have are typically minimal and are statistically more likely to be in cash rather than in a home[1] or in retirement accounts. [2] Lower home ownership and accumulation of retirement funds among BIPOC communities is due to a host of historical reasons that include discriminatory practices.

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[1] NYS Attorney General, *Racial Disparities in Home Ownership*, 10/31/23 available at https://ag.ny.gov/sites/default/files/reports/oag-report-racial-disparities-in-homeownership.pdf (Finding white households in NYS are more than twice as likely to own their home as compared to Black or Latino households, in part due to racially disparate lending practices.); NYS Comptroller, *Home Ownership Rates in New York*, Oct. 2022, available at https://www.osc.ny.gov/reports/homeownership-rates-new-york (New York's annual homeownership rate in 2021 was the lowest in the nation at 55.4 percent, with homeownership rates of 67 percent for White households, 34 percent for Black households, and 29 percent for Hispanic households); see also Stefanos Chen, *The Resiliency of New York's Black Homeowners*, New York Times, Aug. 17, 2021, available at https://www.nytimes.com/2021/08/17/realestate/new-york-black-homeowners.html?referringSource=articleShare.

[2] US Government Accountability Office (GAO), Growing Disparities in Retirement Account Savings, available at https://www.gao.gov/blog/growing-disparities-retirement-account-savings (Aug. 24, 2023)(finding white households had double the median balance than households of all other races); Kelly Anne Smith, America's Racial Wealth Gap In Retirement Savings, Forbes, 9/1/2020, available at https://www.forbes.com/advisor/retirement/retirement-racial-wealth-gap/

Id. When reviewing assets, however, Medicaid counts cash but excludes equity in the applicant's home and retirement accounts, leaving individuals with only cash up to the current asset limit, $32,396 for singles and $44,781 for married couples in 2025.

The disparities in homeownership and retirement savings between New Yorkers of color and white New Yorkers lead to racial inequities. Similar inequities exist for people with disabilities. The asset poverty rate in New York is high generally and varies dramatically by race.[3]

- 23% of New York State's households were considered asset-poor in 2021, making it one of 12 states with the highest asset poverty rates nationally.
- New York is among four states tied for the highest asset poverty rate for Latinx households nationally - 44% compared to 16% for white households in New York State. The asset poverty rate for Black households is 45%.

Increasing the liquid asset limit will make access to health care more equitable. A home worth $1.097 million is exempt from Medicaid in 2025, as is a retirement account. However, a tenant who cannot afford to buy a home and saves $100,000 in cash is disqualified from Medicaid. Low-income homeowners need savings to do home repairs and pay growing property taxes and insurance costs, which are all vital to maintaining their homes. Without sufficient savings, a car repair bill can deplete meager savings.

For the above reasons, NYSBA's Elder Law and Special Needs Section **SUPPORTS** this legislation and urges inclusion in the final budget.

[3] Prosperity Now Scorecard, available at https://scorecard.prosperitynow.org/data-by-issue#finance/outcome/asset-poverty-rate, based on 2021 data.
New York's asset poverty rate, including the equity in a home, is 26.9 % higher than the national average of 24.1%, based on 2016 data. Prosperity Now Scorecard, available at https://scorecard.prosperitynow.org/data-by-issue#finance/outcome/asset-poverty-rate.

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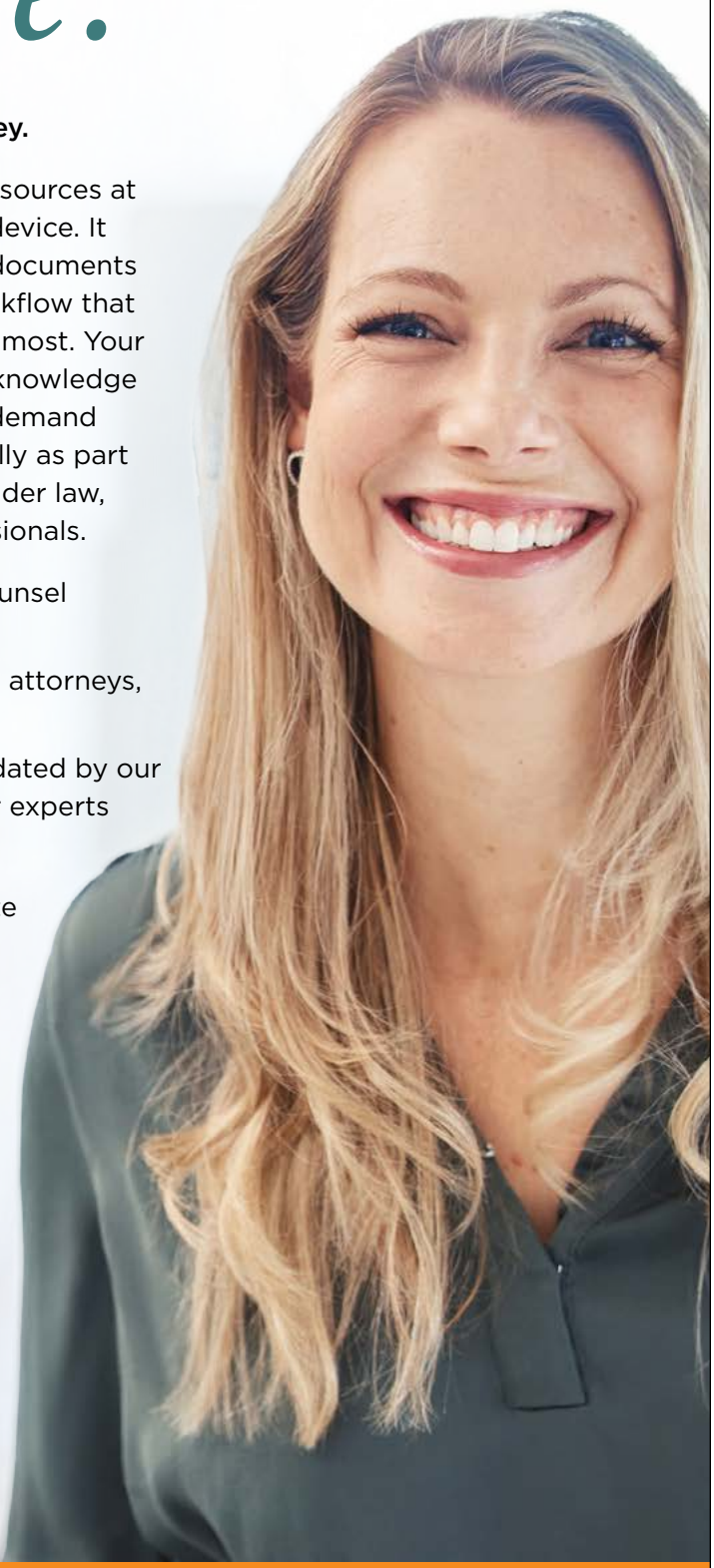

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